HTA Initiative # 11 • October 2003

DECISION-MAKING FOR HEALTH CARE SYSTEMS:

A Legal Perspective

AHFMR
ALBERTA HERITAGE FOUNDATION FOR MEDICAL RESEARCH

104-05320/

Other Titles in this Series

HTA Initiative #1 Framework for Regional Health Authorities to Make Optimal Use of Health Technology Assessment

HTA Initiative #2 Making Managerial Health Care Decisions in Complex High Velocity Environments

HTA Initiative #3 Proceedings of the Conference on Evidence Based Decision Making: How to Keep Score, University of Calgary

HTA Initiative #4 AHFMR Screening Procedure for Use When Considering the Implementation of Health Technology

HTA Initiative #5 Priority Setting in Health Care: From Research to Practice

HTA Initiative #6 AHFMR Screening Procedure for use when Considering the Implementation of Health Technology

HTA Initiative #7 Local Health Technology Assessment: A Guide for Health Authorities

HTA Initiative #8 Minimally Invasive Hip Arthroplasty

HTA Initiative #9 Elements of Effectiveness for Health Technology Assessment Programs

HTA Initiative #10 Emergency Department Fast-track System

Copies of these publications are available electronically at http://www.ahfmr.ab.ca/frames3.html

For more information contact:

Health Technology Assessment Unit
Alberta Heritage Foundation for Medical Research

Suite 1500
10104 - 103 Avenue NW
Edmonton, Alberta
Canada T5J 4A7

Tel. 780 423 5727
Fax: 780 429 3509

DECISION-MAKING FOR HEALTH CARE SYSTEMS: A Legal Perspective

Prepared by:

Gayle A. Almond, RN, BN, LL B

HTA Initiative # 11

Decision-Making for Health Care Systems: A Legal Perspective

Prepared by:
Gayle A. Almond, RN, BN, LL B

Copyright © Alberta Heritage Foundation for Medical Research, 2003

ISBN: 1-896956-65-3 (Print)

ISBN: 1-896856-67-X (On-Line)

ISSN: 1706-7855

All rights reserved.

Design: Interpret Design Inc.

This paper has been prepared on the basis of available information of which the Foundation is aware from public literature and expert opinion and attempts to be current to the date of publication. A primary source of information is the background reports prepared by leading experts for the Romanow Commission on the Future of Health Care in Canada. This paper has been externally reviewed. Additional information and comments relative to the information paper are welcome and should be sent to:

Director, Health Technology Assessment
Alberta Heritage Foundation for Medical Research
Suite 1500, 10104 – 103 Avenue NW
Edmonton, Alberta, Canada T5J 4A7

Tel: 780-423-5727
Fax: 780-429-3509

www.ahfmr.ab.ca

Acknowledgements

The Alberta Heritage Foundation for Medical Research is grateful to the following persons for information and comments on the draft paper. The views expressed in the final paper are those of the Foundation.

Ken Gardener, Capital Health Region
Steve Petz, East Central Health Region
John Ramsey, Capital Health Region
Cam Waddell, Calgary Health Region
Brent Windwick, Field Atkinson, Perraton LLP

Preface

The Alberta Heritage Foundation for Medical Research (AHFMR) health technology assessment initiative series, commenced in March 2000 with "A Framework for regional health authorities to make optimal use of health technology assessment." The purpose of this series has been to provide policy and decision-makers with the best information available on how to redesign their health care structures and processes to effectively respond to the challenge of decision-making in a turbulent health care environment.

This paper arose from a need identified by the health regions in Alberta for a paper to address the emerging legal issues that are beginning to have an impact on how services are delivered and decisions are made.

Other papers in this series are listed on the inside front cover.
Copies of these and other reports can be found at:
http://www.ahfmr.ab.ca/frames3.html

If you have any comments or suggestions to make on this paper, I would be delighted to receive your feedback.

Don Juzwishin
Director, Health Technology Assessment
Alberta Heritage Foundation for Medical Research

ABOUT THE AUTHOR

As a nurse-lawyer with bedside acute care and senior management experience in Saskatchewan and Alberta, Gayle Almond brings an appreciation of the realities challenging decision-making in today's rapidly changing health care system.

Table of Contents

Background to this Report 1

Introduction 3

1. Vision: Improve Quality of Life 4

2. Principles: Guides for Decision-Making 5

3. Legal Liability: Its Effect on Decision-Making in Health Care Systems 6

- Principles of Administrative Law 7
- Principles of Fundamental Justice 8
- Equality of Services 9
- Amendments to the Criminal Code 14
- Tort (Negligence/Malpractice) Law 14

4. Case Law Review 19

5. In Summary 20

Bibliography 21

- Books and Book Chapters 21
- Journal Articles/Manuscripts 22
- AHFMR Publications 23
- Newspaper Articles 24
- Web Sources 24
- Government Documents 25
- Background Reports prepared for the Romanow Commission on the Future of Health Care 26
- Other 29
- Legislation 29
- Case Law 29
- Legal Opinions 30

Background to this Report

- The recent flurry of discussion papers written to inform the Commission on the Future of Health Care in Canada and the Standing Committee on Social Affairs, Science and Technology have raised a new awareness of issues from the legal perspective of what considerations trustees and decision-makers ought to take into account when undertaking their responsibilities of stewardship for the public health care system. This paper is an attempt to briefly highlight the emerging issues from a legal perspective and how a decision-making framework might be structured to respond to these new challenges.
- This paper is part of a series of Health Technology Assessment Initiatives to support Regional Health Authorities in the use of evidence in decision-making. It builds on the Self-Assessment Tool, developed from the "Proceedings of the Conference on Evidence Based Decision Making: How to Keep Score," held September 11, 2000 (29).
- This paper provides information on contemporary legal considerations for decision-making in health care systems. The methodology is an analytical mix of case law, legislation and secondary sources.
- It is intended for all levels of decision-makers, from policy to planning, to provision of services.
- It encompasses a series of issues, with a focus on emerging technologies and their implication for resource allocation. These are issues which decision-makers ought to consider in the process of determining what and how services should be delivered.
- It is based on the assumption that Canadians will continue to value a health care system where the risk of illness is shared through a public insurance scheme, which ensures access to health care based on need, irrespective of the ability to pay.

Introduction

In times of fiscal constraint, decision-makers are challenged to meet public expectations within limited financial and human resources, without incurring increased liability. The rapid pace of the diffusion of medical technology, targeted advertising, and consumer access to health information raises public expectation of their perceived "right" to an ideal health care. It is anticipated there will be an increase in legal challenges, as individuals perceive that their health care "rights" are being limited.

Decisions related to health care, whether in identifying needs, priority setting, resource allocation, or service delivery, often fail to take into account the complexity of health care and often prove to be less than satisfactory. The challenge is to ensure that the best evidence and information is brought forward to inform the question of what ought to make up the elements of health care delivery. It is important to note that there is no right way of decision-making. However, decision-making needs to be done within a clear framework, which guides the overall process, ensuring transparency, openness, and accountability to those who have interests in the outcomes. Decisions should be based, where available, on the best evidence, which is outcome-focused, clearly documented, and publicly communicated.

1. Vision: *Improve Quality of Life*

The great British epidemiologist A.L. Cochrane, as a medical student in the 1930s, attended a national rally in London on the possibility of a national health service. He writes in his memoirs,

> *I decided to go alone with my own banner. After considerable thought I wrote out my slogan:* ALL EFFECTIVE TREATMENT MUST BE FREE. *I had a deep inner feeling that this was absolutely right: although I doubt very much if I would have passed a viva on the meaning of 'effective'! The slogan, I regret to say, was a flop... but I still thought it had something.*
>
> (Cochrane 1989, originally published 1972 [2])

The Canadian health care system was founded on the social right that all citizens ought to be able to access basic health care based on need, irregardless of the ability to pay. Candace Redden noted that, "*Health is central and not adjunct to social, political and cultural life*" (Redden 2002, 17 [83]).

2. Principles: *Guides for Decision-Making*

Health care is embedded in politics, culture and history. Services are planned to meet the needs of the general population, but delivered to individuals based on their own needs and preferences. Decision-making requires an intricate appreciation of the many factors that impact on the system, based on input from a variety of sources, to make best guess predictions of outcomes and potential unintended consequences.

Health care is in constant change. Planning to meet present health needs requires an appreciation of future needs. The goal is to create a system where service provision is flexible and innovative: balancing individual and community needs, and continuously striving for quality improvement.

A commitment to excellence requires an organizational culture that is constantly striving to improve quality patient and community care, where innovative, research-based principles of practice are promoted and encouraged. It requires a culture where innovation is valued, and where there are incentives for positive change and for challenging the status quo. A commitment to excellence is two-fold: evidence of best practice is disseminated, as in the Clinical Practice Guidelines; and health care providers are empowered to continuously evaluate and readjust practices based on outcomes.

Sustainability *"depends on the financial, organizational and epistemic capacity to respond adequately to the health needs of current generations without compromising the system's ability to meet the needs of future generations"* (Imbeau et al 2002 [68]). Financial sustainability and efficient utilization of scarce resources will be enhanced through a commitment to excellence with attention to quality of care, integration, and coordination of services.

Health care decisions require four considerations:

- **Transparency:** decisions must be publicly accessible.
- **Reasonableness:** rationale for decisions should provide a reasonable account of how the organization provides value for money in meeting the varied health needs of a defined population under reasonable resource constraints.
- **Appeals:** there should be a mechanism for challenge and dispute resolution.
- **Enforcement:** should be either voluntary or through public regulation of the process.

(Daniels 2000, 92 [3]), discussed in (Ramsay 2002, 12 [82]).

3. Legal Liability: its Role in Decision-Making in Health Care Systems

The legal system in Canada has been a primary influence on the development of the health care delivery systems in the provinces. Emerging forces such as health reform, regionalization, questions about citizen entitlement, consumerism, the role of the private sector, the rapid emergence of new technologies, and access to services have impacted on the health care system. The legal system has contributed to the delineation of new issues as well as solutions to emerging problems. Malpractice, or negligence law, continues to exert influence on the right of Canadians to a quality health care system. With increased recognition of the impact of medical adverse events on morbidity and mortality, it is anticipated that there will be increased malpractice claims and public focus on quality of care.

Although Canadians generally believe the Canada Health Act legally entitles them to health care, it does not. Legal rights, if there are any, are enshrined in provincial legislation.

Constitutional responsibility for health care is primarily provincial. The federal government enacted the *Canada Health Act* 1984 (CHA), which governs federal transfer payments to the provinces for the purpose of health care. In effect, the *Canada Health Act*, penalizes provinces who fail to meet its principles by reducing transfer payments. Although Canadians generally believe the *Canada Health Act* legally entitles them to health care, it does not. The *Canada Health Act* contains five principles, that are supported by the provinces: public administration, comprehensiveness, universality, portability and accessibility. Legal rights, if there are any, are enshrined in provincial legislation. Since the *Charter of Rights and Freedoms* 1982, there have been thirty-three challenges to health care service delivery, with only eleven successful challenges. The majority of the successful challenges have been in the area of section 15, the equality section, in expanding access to health services (Greschner 2002 [65]).

Potential areas of liability could include:

- unreasonable delays in determinations of what services or treatments should be provided,
- awareness of medical adverse events and failure to address,
- funding decisions or physician practice that would perpetuate the continued use of outdated treatments, or
- health care providers failure to keep up to date with medical knowledge.

Regional Health Authorities have legal responsibility in the following areas:

- **Principles of administrative law:** authority from the Minister of Health to assess needs and provide health services, within available resources, exercised with due diligence or care.
- **Principles of fundamental justice** (*Charter* s. 7): public input, fairness, appeal process.
- **Equality of services** (*Charter* s. 15): service provision decisions must not unfairly discriminate, accessibility/availability of services.
- **Amendments to the Criminal Code** (proposed Bill C-284): may increase board and management legal responsibility where practices place staff and patients at risk.
- **Tort (negligence/malpractice) law:** quality of care, physician conflict.

Each of these will now be examined.

Principles of Administrative Law: *Legislated authority, exercised with due diligence*

The provincial government, has delegated responsibility to Regional Health Authorities to:

- Promote and protect the health of the population in the region and work toward the prevention of disease and injury.
- Assess the health needs of the people living in the region.
- Determine priorities for the provision of health services in the region and allocate resources accordingly.
- Ensure reasonable access to quality health services is provided in and through the region, and
- Promote the provision of health services in a manner that focuses on the needs of individuals and communities and support integration of services and facilities in the region.

(*Regional Health Authorities Act*, s. 5)

As a general principle, boards and management are not legally liable for policy decisions made in good faith. Due diligence is careful consideration of relevant information and potential impacts of decisions. Relevant information includes a consideration of the quality of the information. Boards are responsible for making decisions that fall within their mandate.

Regional health authorities charged with the provision of services based on community needs are responsible for an appreciation of community needs, and an understanding of competing interests, including limitations, in resource allocation decisions.

There is no immunity for operational decisions. Legal liability of decision-makers, is an evolving area of the law and needs to be carefully considered. It is recommended that decision-makers operate as if they would be held legally responsible.

Seeking information based on evidence, such as a health technology report on a topic under consideration by the health region, may be one strategy to demonstrate due diligence.

If decisions are challenged, the Court would examine the committee structure and mandate, its process for decision-making and ultimately, its decisions. The test of negligence is what a reasonably careful and competent, appropriately constituted committee would or would not do in the same circumstances (as discussed in Somerville 1999, 169 [20]). In the past, the legal system has been reluctant to interfere in resource allocation decisions, however, there are a number of cases which potentially could impact future decision-making and sustainability.

Seeking information based on evidence, such as a health technology report on a topic under consideration by the health region, may be one strategy to demonstrate due diligence.

Principles of Fundamental Justice: *Public input, fairness, appeal process (Charter of Rights, s.7)*

Fundamental or natural justice requires that parties whose interests are impacted must be given the opportunity to participate in decisions, policy and regulatory settings, thus ensuring decisions are publicly debated before they are implemented. It is unclear, if a legal challenge was raised, what level of involvement from affected parties would satisfy the Court – whether it is input into the decision, or involvement in the actual deliberation. Due process requires that adequate notice is given, with time to respond and the opportunity to be heard by an impartial decision-maker (as discussed in Jackman 2002 [69]). The importance of input into resource allocation decisions is frequently overlooked in favour of decisions being made at the highest level and thus farthest away from those whose interests are impacted. This approach may seem easiest, but it places decision-makers in a position of being challenged and at risk. There are many strategies for soliciting community input, including the use of citizen juries, ethics committees, and community representatives.

Equality of Services: *Service provision decisions must not unfairly discriminate, accessibility/availability of services (Charter of Rights, s. 15)*

Equality means that all services are available equally to all citizens. The principle of equality fails to take into account the social context of health care service delivery. Individuals and communities are not equal. Their needs are different. However, equality may require that where a decision is made to provide a service, it should be made equally available to those in need.

Equity may mean provision of a different service, dependent upon individual or community needs. If the goal is to improve health, then equity and recognition of different needs will be a means to ensure the true meaning of universal access to health care based on needs. In *Auton* (99), the BC Court held that autistic children's needs are different, and to achieve equality with other children, they are entitled access to a specialized service.

The Courts will examine the rights of individuals under a *Charter of Rights* challenge as they balance against the overall objectives of the scheme of health care service delivery.

Challenges may be brought in the areas of:

- Increasing the scope of services.
- Access to a service:
  - level of service – scarcity of resources,
  - equality of access to a service,
  - timeliness/availability.
- Withdrawal of a service.

Increasing the scope of services

Individuals have been successful in increasing the scope of services provided by proving that they have been substantively treated differently by being denied access because of a disability, which cannot be rationally justified as minimally impairing their rights to be treated equally. Charter challenges of this type must fall under a recognized disability. Court decisions on the distribution of scarce resources may have a direct impact on health care sustainability. Future Supreme Court decisions will need to be carefully monitored for their impact on decision-making. Equity may require that where individuals are disadvantaged, they may require a greater proportion of resources to attain equality. This disproportional need must

be carefully balanced against the needs of the majority. The rationale behind decisions should be well-documented and based on evidence, where it is available, that supports these decisions. It is reasonable to assume that with increased technology, targeted advertising, and consumer expectations, this process of decision-making and balancing of needs with resources will become the focus of public scrutiny and debate. Decision-making processes, which include public input, will provide decision-makers with a valuable basis for their considerations.

The Court in its deliberations would consider a treatment and its alternatives in the following context:

- Is the treatment experimental or proven?
- Is the treatment or service provided in other jurisdictions?
- What alternatives are available? (availablity includes accessiblity and timeliness)
- What is the effectiveness of the treatment/alternatives?
- What is the risk of not providing the treatment?
- What is the risk of the treatment/alternatives?
- Cost – where cost is high – would the provision of the service result in a reduction of beneficial services in other areas?

(*Auton* 2000 [99], *Eldridge* 1997 [103], *Stein* 1999 [111])

A good example is given by *Auton* (2000 [99]), in which the BC Supreme Court recognized a section 15 Charter challenge for children with autism, as having a recognizable disability. The Court examined the requested treatment, alternative treatments, the cost of the treatment, risks and benefits of providing and not providing the treatment, and ruled that autistic children deserve to have access to those services which would improve their health as functioning members of society. The cost, significant per child at $60,000 per year, was a small percentage of the overall operating costs. In this case, there were limited alternatives, with poor accessibility and the treatment was being provided in Alberta and Ontario. The Supreme Court of Canada has granted leave to hear this case in the spring of 2004. A decision in this case could have implications in the following areas:

- whether there is a right to health care protected under s. 7 of the *Charter*,
- whether a decision not to fund a service is discrimination based on age or disability contrary to s. 15 of the *Charter*,
- whether funding restraints are recognized as reasonable limits, and

- expanding the definition of what is medically necessary and therefore must be publicly insured under the *Canada Health Act*.

Currently, publicly insured medically necessary services, has by implication been limited to hospital-based services under the direction of a physician. This case may have national implications on defining what is necessary to include community-based services. Currently, these services tend to be defined as "discretionary" or not falling under the physician or hospital based publicly insured services.

Access to a service

Level of service – scarcity of resources

Case law, or the study of legal cases, suggests that where there is an actual scarcity of resources, as in human resources, the Court will be reluctant to impose a higher standard of service provision (*Bateman* 1993 [100]). However, where decisions have been made on the basis of reducing costs to the detriment of the individual patient, the Courts, in obiter, have indicated that the duty of care to individuals over-rides resource restraints (*Law* 1994 [107], *Gosselin* 2002 [104]). The Supreme Court of Canada may provide direction in this area when the *Auton* case is heard in the spring of 2004.

The Court will examine whether decisions were based on sound information and evidence. Where individual versus community benefits have to be balanced, it might be acceptable not to provide an expensive service of questionable benefit, if it would mean that others would be denied access to services with proven value (Stadiotto et al 2000 [21]). This evidence would be invaluable in demonstrating a reasonable limit under s. 1 of the *Charter*.

Equality of access to a service

Where a decision is made to provide a service based on assessed need, it should be provided equally to those in need. There should be no discrimination with the service delivery. There have been successful challenges regarding access to services where they were available to one sex but not another, as in a case where a step down unit was available for male patients, but unavailable for female patients (*J.C. v. Forensic Psychiatric Service Commissioner* 1992 [106]). In this case the number of female patients may have made it difficult to justify the additional expense. In those instances, decision-makers should consider alternatives to provide services, and carefully document the rationale.

Examples of services, which in the future could potentially be challenged include differences of treatment between men and women, availability of

suitable facilities for residents with Alzheimers, and treatment and services for the physically and mentally disabled.

Timeliness/Availability

Accessibility includes availability and reasonable wait times. Availability may include an assessment of transportation, especially in rural areas. Reasonable, or acceptable wait times for services will depend upon the impact of the wait on the individual patient. In determinations of reasonable accessibility to services, the onus will be on the decision-maker to clearly understand the current service delivery, availability and access to the service including wait times, and associated risks and alternatives. Further considerations include whether the service is medically necessary, high risk, and whether the treatment is proven and available in other jurisdictions.

> There is case law which suggests, that where a medically necessary service is unavailable, or the wait time is onerous and there are associated risks, the individual should be informed of the unavailability of the service and advised of alternatives. It is recommended that physicians advise patients of wait times and the associated risk, as well as any alternatives (Caulfield 2002 [1, 57]).

In Quebec, a cancer patient was awarded costs for services he received in the US because of unavailability of a proven treatment, and onerous wait times for surgery (Stein 1999 [111]). This case raises two interesting questions. Is there an onus on authorities to ensure that wait times are reasonable to the condition, and if unable to provide the service within the region, are they then obligated to make arrangements with other regions, private service providers, or other provinces to provide the service?

If so, then it is reasonable to assume that if Regional Health Authorities do not manage wait times, or plan for alternatives, there may be an action for negligence where the wait time was a contributing factor to damages suffered by patients. Alternatively provinces will have increasing pressure to compensate patients who have incurred expenses accessing services in other jurisidictions. It is reasonable to assume that there may be an onus on provincial or Regional Health Authorities to assist patients to access services outside of their jurisdictions. If Patient Charter of Rights are implemented, they will increase public scrutiny of wait times and increase the accountability to manage wait times (Mazankowski Report 2001 [46], Romanow Commission 2002 [49]).

It is anticipated that there will be increased public scrutiny of availability, and timeliness to services. In rural settings, this may prove to be an additional challenge with access to emergency services and transportation being identified issues.

Section 7 of the *Charter of Rights*, dealing with the right to life, liberty and security of the person has not been successfully argued as giving a right to health. However, it is feasible that it could be successfully argued that the right to life, liberty and security of the person is compromised by unreasonable wait times, and that the inaccessibility did not conform to the principles of fundamental justice. If this argument is successful, section 7 could be applied to enforce accountability for reasonable access to services. The reasonableness of "wait times" has also been raised in the gambit of criminal law, where due process requires a trial in a reasonable time period.

In Canada, physician and hospital-based services, which are medically necessary, must be publicly insured under the *Canada Health Act*. This principle is espoused in provincial legislation. The Supreme Court has granted leave to *Chaoulli* (102) in the summer of 2004. In this case, the patient's physician challenged the monopoly of publicly insured services. Hartt and Monahan noted that "*....if a government rations the supply of health care services, therefore failing to provide Canadians with timely access to medically necessary services through the publicly funded system, it cannot simultaneously prevent individuals from purchasing such services outside of that flawed system*" (Hartt and Monahan 2002, 3, 4 [17]). If this case is successfully argued, under s. 7 of the Charter, it is feasible that the *Canada Health Act* and provincial legislation barring privately insured services, for physician and hospital based medically necessary services, could be found to be unenforceable, where access to the publicly insured services places individuals at risk.

Withdrawal of a service

The *Charter of Rights* will have a role in ensuring that services are withdrawn or denied only in accordance with the principle of fundamental justice (Canadian Bar Association Task Force 1993). In *Eldridge* (1997 [103]) the services of deaf interpreters were withdrawn. A successful argument was made that this denied access to health services for the deaf under the equality provision of the Charter. It is reasonable to conclude that where a decision is made to provide a service, and the service is then withdrawn, the Court would require evidence that the decision-makers considered alternatives, evidence supporting the effectiveness of the treatment or alternatives, the cost of the treatment, and the overall benefit.

Amendments to the Criminal Code: *May increase board and management legal responsibility where practices place staff and patients at risk (proposed Bill C-284)*

The area of adverse events, or incident reporting, is a prime example where patients are placed at risk. This is the area known as "medical adverse events." Authorities need to make themselves aware of potential adverse events, and to proactively plan to reduce the risk. If they fail to proactively plan, an argument could be made that their omission to act contributed to future incidents. It is feasible that if authorities are aware of adverse events, and are aggressively planning to address and reduce the incidents, then the disclosure of events will ultimately reduce risk to patients, and thus reduce risk of liability. The proposed amendments to the *Criminal Code* (Bill C-284), 2003, may increase the liability of all incorporated entities (including municipal corporations and non-profit corporations), directors, and officers to be convicted of an array of crimes, including criminal negligence where staff or the public are at risk (Jobb, *Canadian Business* 2003, 39-43 [18]).

Tort (Negligence/Malpractice) Law: *Quality of care*

Quality of services provided

Quality improvement processes should be aimed at improving the health of the population, anticipated outcomes and ensuring patient safety. They are based on continuously striving to optimize the health of the population and outcomes.

Dr. Woolf, in his article "Patient Safety is Not Enough: Targeting Quality Improvements To Optimize the Health of the Population" noted that, *"The public's well-being requires policymakers to view the system as a whole and consider the potential effect on overall population health when prioritizing care improvements and system redesigns."* As examples, mistakes in health promotion and chronic disease management cost lives but do not affect "safety" (Woolf 2004, 33 [25]).

Monitoring outcomes provides information on assessing the impacts of service delivery and finding best practices, which frequently are a combination of service delivery factors, including clinical practice guidelines based on evidence. This information can then be shared with other health care organizations to improve outcomes in similar populations.

There is increasing public awareness of the risks associated with receiving health care as a result of medical adverse events. Roos, in the article entitled, "Small Area Variations, Practice Style and Quality of Care," while commenting on assessment of the quality of care stated, *"Yet, economics aside, modern medical treatment has significant potential to do harm and to produce pain and suffering. Given the enormous variations in physician practice patterns, quality of care assessments should encompass utilization review"* (Roos 1994, 250 [10]).

There are two aspects to this observation:

- the potential for adverse events is high, and
- physician practice variations may subject patients to treatment that is not optimal.

Based on American statistics, extrapolated to the Canadian population, it is estimated that 10,000 Canadians die each year related to medical adverse events (as reported by Don Berwick, National Quality Council, 2002 [91]). Baker and Norton prepared a report to Health Canada in 2002 on Patient Safety and Healthcare Error in the Canadian Healthcare System reviewing adverse medical events. Based on American, British and Australian studies, 1 in 10 medical events results in a medical adverse event, with 50% of these events considered preventable, with an estimated 70.5% giving rise to disability lasting less than six months, 2.6% resulting in permanent disability, and 13.6% leading to death (Baker et al 2002, chapter 3 [42]). It is impossible to accurately predict the number of Canadians who are injured, or who have a longer length of hospital stay as a result, since reporting of incidents is sporadic. This does not take into account the number of "near misses." A second report on Patient Safety and the Canadian Adverse Event Study, prepared by the Canadian Adverse Events Study Team, based on an acute care patient survey and chart audits is scheduled to be released in February 2004.

Organizations at all levels should address the risks associated with receiving medical services. Where treatments or services place patients at risk, the issue of a full disclosure of the risks, benefits and alternatives of treatment, and consent to accept risks is of critical importance. It is not enough that information is given, the patient must understand and appreciate the information. Documentation is evidence of the discussion and the decisions that take place. With the proliferation of internet information, there is academic legal debate that health care providers may have an emerging duty to ensure that patients are not misinformed and base their decisions on correct information (as presented by Erin Nelson at the National Health Law Conference January 24, 2004).

Health care providers are accountable to patients to provide a reasonable standard of care. The standard of care is determined by examining what is the usual treatment of care provided by similar providers in similar circumstances (*ter Neuzen v. Korn* 1995 [112]). With emerging and evolving technologies, it is feasible that the Court will find that the "legal" standard of care was not provided, even if the care received was the standard or generally accepted medical treatment (Caulfield 2002 [57]). To clarify, if the standard practice is to treat condition y with x, but the research clearly supports treatment with z, then the emerging legal standard of care could potentially be z.

The emerging legal standard of care increases the onus on service providers to be aware of evolving technologies and treatments which are effective; and the importance of an organizational culture that emphasizes innovative practice, where quality improvement processes, monitor, evaluate and improve the results of services. Overly enthusiastic adoption and introduction of new and emerging technologies, which do not demonstrate effectiveness, is also a danger, particularly when the opportunity cost detracts from doing something beneficial for the community.

The Canadian system of negligence, may be a deterrent to a quality improvement process because of the tendency to place blame, and also health care providers' desire to be protected from a legal suit.

Our current legal system provides limited protection for quality improvement processes if they fall under a Quality Assurance Committee as contemplated under the *Evidence Act* s. 9.

Quality improvement initiatives require the reporting and sharing of medical adverse events, including near misses, in an attempt to reduce future incidents. Under the current tort system, patients exposed to the risks of unnecessary procedures or who receive less than optimal treatment, do not have a course of legal action, if they do not suffer measurable damages. Professor Timothy Caulfield, of the University of Alberta, recommends that the tort system should be reformed to a no-fault system (Caulfield 2002[57]). New Zealand in 1972 abolished tort liability and provides an administrative system of compensation without the need to prove fault (Davis et al 2002, found at http://bmj.com/cgi/content/full/326/7380/79). Proponents of no fault insurance suggest that without the fear of legal liability, health care providers will be more forthcoming in the reporting and sharing of medical adverse events.

Furthermore, fear of liability is often cited as a barrier for health care providers to disclose medical adverse events to patients and families.

Patients, with legal suits for medical adverse events, often site their motivation for the action as an attempt to "make sure this doesn't happen to anybody else" or to "get answers on what really happened." Open and frank disclosure of medical adverse events and a process to share information may in effect, reduce liability.

Some provinces and professional organizations are considering mandating incident reporting. It is unclear what impact this will have on liability.

Physician practice variations may subject patients to treatment that is not optimal. Negligence requires that the patient must be harmed by the treatment. Although it is unlikely that tort reform is imminent, there is potential for action from patients who are exposed to unnecessary procedures or who receive less than optimal treatment, but do not suffer measurable harm. As an example: it has been estimated that as many as thirty percent of surgical procedures are unnecessary (Stoddart, et al 1993 [90], Berwick, 2002 [91]). In some countries, before a patient is operated on, they must be assessed by more than one surgeon.

Malpractice or negligence law will continue to demand a high standard of care. Public awareness of emerging and evolving technology, incidents related to medical adverse events, consumerism and access to information will increase public scrutiny of the quality of the care they receive.

The Court may apply the concept of fiduciary duty to increase the onus on decision-makers to protect patients who are vulnerable, such as the elderly resident living in a long-term care facility, children or the mentally disabled.

Potential areas of physician conflict

Individual patient interests vs. community needs

Physicians may be placed in a conflict between their fiduciary duty to provide the patient with the highest standard of care, and the need to meet the needs of the community with cost-efficient/effective care. It is doubtful that the Court will be sympathetic to lowering the standard of care for patients (Caulfield 2002 [57]).

Informed consent

Where wait times place a patient at risk, physicians and specialists ought to disclose the wait times, the risk and alternatives, including private options (Caulfield 2002 [57]).

New and emerging models of care

If physician payment methods are changed to a form of managed care, physicians may be in a conflict of interest between individual patient needs, and the overall business management. New and emerging models of care, where physicians practice in a collaborative setting, either as an employee, or in a closely aligned relationship with health authorities may place physicians in conflict between the collective responsibility for a defined clientele and budgetary responsibility, with a competing duty to individual patients.

4. Case Law Review

Review of the current case law, suggests the following:

- Scarce resources are not a defense to not meeting the standard of care.
- Health care providers, such as physicians, have a duty of care: first to the patient, secondly to resource constraints.
- Actual scarce resources (such as a shortage of skilled workers rather than financial constraints) may be considered.
- Courts will attempt to distinguish between:
  - Type of service:
    - Basic/core services ("medically necessary"), which *ought* to be provided.
    - Extraordinary or discretionary services, which *may* be provided.
  - Type of treatment:
    - Proven/standard, which *ought* to be provided.
    - Experimental, which *may* be provided.
  - Type of patient:
    - Is this patient already disadvantaged, and as a result of their disadvantage are they further disadvantaged?
    - Is the treatment/service available to one person but not another with the same need? Is there a criminal element, or a threat to the security of the person? (Difficult to be successful unless the wait time places the individual at risk.)
  - Alternative treatments vs. the requested treatment/service:
    - Cost-efficiency comparisons.
    - Clinical effectiveness (research-based evidence).
    - Risk and benefits of the treatment.
    - Risk and benefits of the alternatives.
  - Risk of not providing the treatment.
  - Accessibility – availability and timeliness.
  - Cost (including overall system cost). Would the provision of this treatment/service deny needed treatment/service to others? This is an important consideration that needs to be documented for high cost treatments.

5. In Summary

With increased public awareness of emerging and evolving technology, higher expectations, consumerism, and the focus on quality, those empowered to make decisions and to deliver health care services will face increased scrutiny and legal responsibility. Public expectations of health care will continue to exert tremendous pressure on decision-makers. Canadians want to know that health care services will be there when they need them and that the services they receive are of a high quality. Technological advances in genetics and treatments, as well as targeted advertising and consumerism, contribute to expectations and demands which may exceed available resources. Health research, based on valid methodology with generalizable results to the local context, will continue to play a valuable role in evidence-based decision-making. Creating organizational cultures that foster research and innovative practices in a research model, at all levels of the organization, will contribute to quality of services that are cost-efficient and achieve expected results or outcomes.

Health care providers will continue to be held to a high standard of care and there is potential that the standard of care will be a higher standard than what may be generally accepted practice. The onus will be on health care providers to be aware of evolving technologies and differentiate between those which are effective and ineffective. Clinical practice guidelines based on sound evidence will provide a measure of comfort. Informed consent should include patient awareness of wait times, associated risks, and alternatives.

In the past, decision-makers were immune from the effects of policy decisions, where the decisions were made in good faith and with due diligence. Increased accountability, the potential amendment of the *Criminal Code* under Bill C-284 to increase liability where staff or the public are at risk, a legislated Patient Charter of Rights, mandatory reporting of adverse events in some provinces, and the call for tort reform will have an impact on liability. Liability for decision-makers is an evolving area of the law and will need to be monitored closely.

However, a process based on the value of improving the quality of care, and a decision-making framework based on evidence-based outcomes that is accountable and transparent and follows the principles of fundamental justice, will reduce both the risk of legal challenges and the success of challenges that will undoubtedly be raised.

Bibliography

Books and Book Chapters

1. Caulfield, Timothy. 2002. Malpractice in the age of health care reform. *Health Care Reform and the Law in Canada*. Edited by Timothy Caulfield and Barb Von Tigerstrom. Edmonton: University of Alberta Press: 11-36.

2. Cochrane, A. L. *Effectiveness and efficiency: random reflections on health services*. London: Nuffield Provincial Hospitals Trust.

3. Daniels, Norman. 1972. Accountability for reasonableness in private and public health insurance. *The Global Challenge of Health Care Rationing*. Edited by Angela Coulter and Chris Ham. Buckingham and Philadelphia: Open University Press, 2000: 87-106. (As discussed in C. Ramsay. A framework for determining the extent of public financing of programs and services, for the Romanow Commission)

4. Flood, Colleen M. 2002. Moving medicare home: the forces shifting care out of hospitals and into homes. *Health Care Reform and the Law in Canada*. Edited by Timothy Caulfield and Barb Von Tigerstrom. Edmonton: University of Alberta Press: 131-156.

5. Ignatieff, M. 2000. Does history matter. *Great Questions of Canada*. Edited by R. Griffiths. Toronto: Stoddart.

6. Litman, Moe. 2002. Fiduciary law and for-profit and not-for-profit health care. *Health Care Reform and the Law in Canada*. Edited by Timothy Caulfield and Barb Von Tigerstrom. Edmonton: University of Alberta Press: 85-130.

7. Morreim, E. Haavi. 2001. *Holding Health Care Accountable – Law and the New Medical Marketplace*. New York: Oxford University Press.

8. Redden, Candace Johnson. 2002. *Health Care, Entitlement and Citizenship*. Toronto: University of Toronto Press; Institute of Public Administration of Canada; Series in Public Management and Governance.

9. Rokeach, M. 1972. *Beliefs, Values and Attitudes: A Theory of Organization and Change*. Washington: Jossey-Bass Inc.

10. Roos, N. P. and L. L. Roos. 1994. Small area variations, practice style and quality of care. *Why Are Some People Healthy and Others Not? The Determinants of Health of Populations.* Edited by Robert G. Evans, Morris L. Barer, Theodore R. Marmor. New York: Aldine de Gryter: 287-316.

11. Von Tigerstrom, Barbara. 2002. Human rights and health care reform: a Canadian perspective. *Health Care Reform and the Law in Canada*, edited by Timothy Caulfield and Barb Von Tigerstrom. Edmonton: University of Alberta Press: 157-185.

12. Windwick, Brent.2002. The challenge and the future. *Health Care Reform and the Law in Canada*, edited by Timothy Caulfield and Barb Von Tigerstrom. Edmonton: University of Alberta Press: 245-250.

13. Wolfson, M.C. 1994. Social proprioception: measurement, data and information from a population health perspective. *Why Are Some People Healthy and Others Not? The Determinants of Health of Populations*, edited by Robert G. Evans, Morris L. Barer, Theodore R. Marmor. New York: Aldine de Gryter: 287-316.

Journal Articles/Manuscripts

14. Caulfield, Timothy A. 1996. Wishful Thinking: Defining "Medically Necessary" in Canada. *Health Law Journal*; 4: 63-87.

15. Cherniawsky, Katherine. 1996. Enforcement of Health Care Rights and Administrative Law. *Health Law Journal*; 4: 35.

16. Giacomini, Mita K. 1999. The which-hunt: assembling health technologies for assessment and rationing. *Journal of Health Politics, Policy and Law*; 24 (4): 715-758. (As discussed in C. Ramsay, A framework for determining the extent of public financing of programs and services, for the Romanow Commission).

17. Hartt, Stanley H. and Patrick J. Monahan. May 2002. The Charter and Health Care Guaranteeing Timely Access to Health Care for Canadians. *C.D.Howe Institute Commentary*; Toronto: No. 164.

18. Jobb, Dean. 2003. Who's responsible? Ottawa is overhauling the law to make it easier to convict corporations of crimes. *Canadian Business*; 76(4): 39-43.

19. Sawyer, D. M. and J. R. Williams. 1995. Core and comprehensive health care services 3: Ethical issues. *Canadian Medical Association Journal*; 152 (9): 1409-1411. Available at: www.cmaj.ca/cgi/content/abstract/152/9/1409 (accessed 2003 October 30).

20. Somerville, M. A. 1999. The ethics and law of access to new cancer treatments. *Current Oncology*; 6 (3): 161-174.

21. Stadiotto, R. and J. Boudrea. 2000. Resource allocation and accountability in health care. *Health Law in Canada*; 20 (3): 40-52.

22. Walters, D and D. Morgan. 1995. Core and comprehensive health care services 2: quality-of-care issues. *Canadian Medical Association Journal*; 152 (8): 1199-1204.

23. Williams, J.R. 1997. CMA's core-services framework featured at international conference. *Canadian Medical Association Journal*; 156 (8): 1192- 1193.

24. Wilson, R., MS. Rowan, and J. Henderson. 1995. Core and comprehensive health care services 1: Introduction to the Canadian Medical Association's decision-making framework. *Canadian Medical Association Journal*; 152: 1063-1066.

25. Woolf, Steven H. 2004. Patient Safety is Not Enough: Targeting Quality Improvements to Optimize the Health of the Population, *Annals of Internal Medicine*; 140 (1): 33-36.

Alberta Heritage Foundation for Medical Research Publications

26. Hailey, David and Christa Harstall. 2001. Decisions on the status of health technologies. Edmonton: AHFMR, Information Paper IP-4.

27. Hailey, David. 2002. Local health technology assessment: a guide for health authorities. Edmonton: AHFMR, HTA Initiative #7.

28. Juzwishin, Don. 2000. Framework for regional health authorities to make optimal use of health technology assessment. Edmonton: AHFMR, HTA Initiative #1.

29. Juzwishin, Don, editor. 2001. Proceedings of the conference on evidence based decision making: how to keep score? Edmonton: AHFMR, HTA Initiative #3.

30. Juzwishin, Don and Wendy Schneider. 2002. AHFMR screening procedure for use when considering the implementation of health technology. Edmonton: AHFMR, HTA Initiative #6.

31. Reay, Trish. 2000. Making managerial health care decisions in complex, high velocity environments. Edmonton: AHFMR, HTA Initiative #2.

Newspaper Articles

32. Armstrong, Jane. 2003. Plug in some new thinking. *The Globe and Mail* February 4, 2003: A17 (print edition). Available at: www.globeandmail.com/servlet/ArticleNews/printarticle/gam/20030204/COENVIRON (accessed 2003 October 30).

33. Gordon, Ann B. 2002. Success story: culture shift spawns error reduction at Alexian Brothers Medical Center. *IHI Newsletter #22* February. Available at: www.ihi.org/resources/successstories/cio103culture.asp (accessed 2003 October 30).

34. Niedowski, Erika. 2003. Reforms for patient safety listed as critical: 'Very little has been done' to prevent medical errors. *Baltimore Sun* February 21. Available at: www.baltimoresun.com/templates/misc/printstory.jsp?slug=bal%2Dte%2Esafety21feb21 (accessed 2003 October 30).

Web Sources

35. Canadian Institute for Health Information. 2000. National health expenditure trends, 1975-2000 report. Available at: www.cihi.ca

36. Canadian Institute for Health Information. Health care in Canada 2001. Available at: www.ecomm.cihi.ca/ec/product.asp?code=01HCR%28HC%29PDF (accessed 2003 October 30).

37. Canadian Institute for Health Information. Health care in Canada 2002. Available at: www.cihi.ca (accessed 2003 October 30).

38. Canadian Life and Health Insurance Association. Canadian life and health insurance facts – 2001 edition. Available at: www.clhia.ca (accessed 2003 October 30).

39. Health Quality Council, Saskatchewan. Available at: www.hqc.sk.ca (accessed 2003 October 30).

40. S.E.A.R.C.H. Program (Swift Efficient Application of Research in Community Health). Co-sponsored by University of Alberta, University of Calgary, Alberta Health and Wellness, Rural Physician Action Plan, Alberta Family Practice Research Network, Alberta's Regional and Provincial Health Authorities, and Alberta Heritage Foundation for Medical Research. Available at: www.ahfmr.ab.ca/search.shtml (accessed 2003 October 30).

Government Documents

41. Alberta Health and Wellness. 2000. *Strategic Directions and Future Actions: Healthy Aging and Continuing Care in Alberta*. Edmonton.

42. Baker, G. Ross and Peter Norton. 2002. *Patient Safety and Healthcare Error in the Canadian Healthcare System: A Systematic Review and Analysis of Leading Practices in Canada with Reference to Key Initiatives Elsewhere: A Report to Health Canada*. Found at www.hc-sc.gc.ca/english/care/report/index.html.

43. Broda Commission. 1999. *Healthy Aging: New Directions for Care & Long Term Care Review: Final Report of the Policy Advisory Committee*. Alberta.

44. Fyke Commission. 2001. *Caring for Medicare: Sustaining a Quality System*. Saskatchewan.

45. Kirby Committee. 2002. *The Health of Canadians, volume 4: Background report*. Ottawa: Federal Senate Committee. Available at: www.parl.gc.ca/37/1/parlbus/commbus/senate/com-e/SOCI-E/rep-e/repintsep01-e.htm (accessed 2003 October 30).

    - *The Health of Canadians, volume 2: Current Trends and Future Challenges*. January 2002.
    - *The Health of Canadians, volume 5: Principles and Recommendations for Reform – Part I*. April 2002.
    - *The Health of Canadians, volume 6: Recommendations for Reform*. October 2002.

46. Mazankowski Commission. 2001. *A Framework for Reform: Report of the Premier's Advisory Council on Health*. Edmonton. Available at www.premiersadvisory.com (accessed 2003 October 30).

47. National Forum on Health. 1995. *Canada Health Action: Building on the Legacy. Vol. II, Values Working Group Synthesis Report*. (See also Vail, S. *Canadians' Values and Attitudes on Canada's Health Care System – A Synthesis of Survey Results*. The Conference Board of Canada, January 2001).

48. National Forum on Health. 1997. *Canada Health Action: Building on the Legacy, Final Report of the National Forum on Health*. Ottawa.

49. Romanow Commission. 2002. *Building on Values: the future of health care in Canada*. Ottawa: Commission on the Future of Health Care in Canada.

Background Reports Prepared for the Romanow Commission on the Future of Health Care

50. Abelson, Julia Ph. D., John Eyles, Ph.D. 2002. Public participation and citizen governance in the Canadian health system. Discussion Paper No. 27.

51. Armstrong, Pat Ph.D. and Hugh Armstrong, Ph.D. 2002. Planning for care: approaches to health human resource policy and planning. Discussion Paper No. 28.

52. Association of Canadian Academic Healthcare Organizations. 2002. Achieving excellence and supporting innovations: the role of Canada's teaching centres in a sustainable health care system.

53. Boychuk, Gerard W. 2002. The Changing Political and Economic Environment of Health Care in Canada. Discussion Paper No. 1.

54. Braen, André. 2002. Health and the distribution of powers in Canada. Discussion Paper No. 2.

55. Campbell, Bruce, et al. 2002. Putting health first: Canadian health care reform, trade treaties and foreign policy. Canadian Centre for Policy Alternatives – Consortium on Globalization and Health.

56. The Canadian Association of Provincial Cancer Agencies (CAPCA). 2001. Brief to the Commission on the future of health care in Canada.

57. Caulfield, Timothy. 2002. How do current common law principles impede or facilitate change? Discussion Paper No. 24.

58. Deber, Raisa B., Ph.D. 2002. Delivering health care services: public, not-for-profit, or private? Discussion Paper No. 17.

59. Denis, Jean-Louis. 2002. Governance and management of change in Canada's health system. Discussion Paper No. 36.

60. Dickinson, Harley D. 2002. How can the public be meaningfully involved in developing and maintaining an overall vision of the health system consistent with its values and rinciples? Discussion Paper No. 33.

61. Evans, Robert G. 2002. Raising the money: options, consequences, and objectives for financing health care in Canada. Discussion Paper No. 27.

62. Fierlbeck, Katherine. 2002. Paying to play? Government financing and health care agenda setting. Discussion Paper No. 15.

63. Flood, Colleen M. and Sujit Choudry. 2002. Strengthening the foundations: modernizing the Canada health act. Discussion Paper No. 13.

64. Glouberman, Sholom, Ph.D., and Brenda Zimmerman, Ph.D. 2002. Complicated and complex systems: what would successful reform of medicare look like? Discussion Paper No. 9.

65. Greschner, Donna. 2002. "How Will the Charter of Rights and Freedoms and Evolving Jurisprudence Affect Health Care Costs?" Discussion Paper No. 20.

66. Grignon, Michel, Valerie Paris and Dominique Polton with the co-operation of Agnes Couffinhal and Bertrand Pierrard. 2002. Influence of physician payment methods on the efficiency of the health care system. Discussion Paper No. 35.

67. Hogan, Seamus and Sarah Hogan. 2002. How will the ageing of the population affect health care needs and costs in the foreseeable future? Discussion Paper No. 25.

68. Imbeau, Louis M. and Adriana Dudas. 2002. The conditions for a sustainable public health system in Canada. Discussion Paper No. 11.

69. Jackman, Martha. 2002. The implications of section 7 of the Charter for health care spending in Canada. Discussion Paper No. 31.

70. Johnson, Jon R. 2002. How will international trade agreements affect Canadian health care? Discussion Paper No. 22.

71. Lavis, John N. 2002. Political elites and their influence on health-care reform in Canada. Discussion Paper No. 26.

72. Leeson, Howard. 2002. Constitutional Jurisdiction Over Health and Health Care Services in Canada. Discussion Paper No. 12.

73. Maioni, Antonia. 2002. Roles and responsibilities in health care policy. Discussion Paper No. 34.

74. Marmar, Theodore R., Kieke G. H. Okma, and Stephen R. Latham. 2002. National values, institutions and health policies: What do they imply for medicare reform? Discussion Paper No. 5.

75. McKillop, Ian. 2002. Financial rules as a catalyst for change in the Canadian health care system. Discussion Paper No. 19.

76. Migue, Jean-Luc. 2002. Funding and production of health services: outlook and potential solutions. Discussion Paper No. 10.

77. Morgan, Steve and Jeremiah Hurley. 2002. Influences on the health care technology cost-driver. Discussion Paper No. 14.

78. Ouellet, Richard. 2002. The effects of international trade agreements on Canadian health measures: Options for Canada with a view to the upcoming trade negotiations. Discussion Paper No. 32.

79. Pelletier, Rejean. 2002. Intergovernmental cooperation mechanisms: Factors for change. Discussion Paper No. 29.

80. Pivik, Jayne Renne. 2002. Practical strategies for facilitating meaningful citizen involvement in health planning. Discussion Paper No. 23.

81. Premont, Marie-Claude. 2002. The Canada Health Act and the Future of Health Care Systems in Canada. Discussion Paper No. 4.

82. Ramsay, Cynthia, Elm Consulting. 2002. A framework for determining the extent of public financing of programs and services. Discussion Paper No. 16

83. Redden, Candace Johnson. 2002. Health care politics and the intergovernmental framework in Canada. Discussion Paper No. 21.

84. Rocher, Francois and Miriam Smith. 2002. Federalism and health care: The impact of political-institutional dynamics on the Canadian health care system. Discussion Paper No. 18.

85. Rode, Melissa and Michael Rushton. 2002. Options for raising revenue for health care. Discussion Paper No. 9.

86. Shiel, Alan and Gavin Mooney. 2002. A framework for determining the extent of public financing of programs and services. Discussion Paper No. 6.

87. Tomblin, Stephen. 2002. Creating a more democratic health system: A critical review of constraints and a new approach to health restructuring. Discussion Paper No. 3.

88. Tomblin-Murphy, Gail and Linda O'Brien-Pallas. 2002. How do health human resources policies and practices inhibit change? A plan for the future. Discussion Paper No. 30.

Other

89. Deber, R. et al. 1995. *The Public/Private Mix in Health Care*, Parts 1 and 2. As discussed at the National Forum on Health, Ottawa.

90. Stoddart, G. L., M. L. Barer, R. G. Evans and V. Bhatia. 1993. *Why not user charges? The real issues – A discussion paper.* Ontario: The Premier's Council on Health, Well-being and Social Justice: 6.

91. 14th National Forum on Quality Improvement in Health Care, Florida. 2002. Broadcast via satellite, Saskatchewan Health. December 10-11, 2002.

Speakers: Dr. Donald Berwick MD, MPP. Introduction.
Laura Adams. Fundamentals of quality improvement.
Dr. John Oldman OBE, MBA, MB, ChB. E1: How to spread breakthrough improvement to seven million patients in 18 months.

Legislation

92. *Alberta Evidence Act*, RSA 2000, c. A-18, section 9.

93. *Alberta Health Care Insurance Act*, RSA 2000, c. A-20.

94. *Act relating to cash contributions by Canada and relating to criteria and conditions in respect of insured health services and extended health care services* [Short title: *Canada Health Act*], R.S.C. 1985, c. C-6.

95. *Charter of Rights and Freedoms*, 1982.

96. *Health Care Protection Act*, RSA 2000, c. H-1.

97. *Hospitals Act*, RSA 2000, c. H-12.

98. *Regional Health Authorities Act*, RSA 2000, c. R-10.

Case Law

99. *Auton (Guardian ad Litem of) v. British Columbia (Minister of Health)* (2002), B.C.C.A.. No. 538 (B.C.C.A.).

100. *Bateman v. Doiron* (1991), 8 C.C.L.T. (2d) 284 at 293 (N.B.Q.B.), affd (1993), 18 C.C.L.T. (2d) 1 (N.B.C.A.).

101. *Cameron v. Nova Scotia (Attorney General)*. (1999) N.S.J. No. 33 (N.S.S.C), (1999) N.S.J. No. 297 (N.S.C.A.)

102. *Chaoulli c Quebec (Procureur general).* [2002] J.Q. n° 759 (Q.C.A.). (As discussed in Greschner [65] #20, 2002)

103. *Eldridge v. British Columbia (Attorney General)* (1997) 3 S.C.R. 624 (S.C.C.).

104. *Gosselin v. Quebec (Attorney General)* (2002) 4 S.C.R. 429 (S.C.C.)

105. *Granger v. Ontario General Hospital* (1996) O.J. 2129 (Gen. Div.).

106. *J.C. v. Forensic Psychiatric Service Commissioner.* (1992) 65 B.C.L.R. (2d) 386 (B.C.S.C.).

107. *Law Estate v. Simice* (1994), 21 C.C.L.T. (2d) 228 at 240 (B.C.S.C.).

108. *North West Lancashire Health Authority v. A.* (1999) E.W.J. No. 4338.

109. *R. v. Morganteler* (1988), 44 D.L.R. (4th) 385 (S.C.C.).

110. *Reibl v. Hughes* (1980) 114 D.L.R. (3rd) 1 (S.S.C.).

111. *Stein v. Quebec (Regie de l'Assurance-maladie)* (1999) Q.J. n° 2724 QL (Q.S.C.).

112. *Ter Neuzen v. Korn* (1995) 3 S.C.R.674.

Legal Opinions

113. Appleton and Associates. 2000. Re: *NAFTA investment chapter implications of Alberta Bill-11.* Legal opinion prepared for the Canadian Health Coalition. Available at: www.healthcoalition.ca/factsheets/NAFTABill11.pdf

114. Shrybman, S. 2000. *Proposals by Alberta to Privatize the Delivery of Certain Insured Health Care Services.* A Legal Opinion Concerning NAFTA Investment and Services Disciplines and Bill 11 prepared for the Canadian Union of Public Employees.